State of Washington
Department of Labor & Industries

Summary Report

Chapter 1

Project to Improve the Quality of Independent Medical Examinations

Downloadable Version Part 2 of 3

Med Fx, LLC
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The Assessment Phase

Major Findings from the Stakeholder Interviews

The interviewees defined a "high-quality IME" as one having the following attributes and outcomes:

- Perceived by primary stakeholders as humane, thorough, expert, reasonable, and objective
- An adequate, accurate, and appropriate patient assessment
- A logical opinion derived from a patient assessment and sound medical reasoning
- Meets expectations for format and content
- Is effective, e.g.
    - Clarifies situation and perceptions
    - Answers questions
    - Provides impartial statement of worker's condition and future needs
    - Both opinion and examiner are credible in court

In general, stakeholder participants reported two major types of issues, those that are process-related and those that are content-related.

IME Process-related Perceptions

Use and Appropriateness of IMEs

On the issue of whether an IME may be required, most participants felt that:

- The information requested is generally already available in the file
- Attending physicians and independent medical examiners are often asked for data that is duplicative
- Examiners find the answers in the medical records sent for the examination

- A desk review by Occupational Nurse Consultants, Assistant Medical Directors or an Attending Physician's (AP) consultant could answer questions now sent for IME, although this may require training in medical analysis, particularly soft-tissue problems.

In terms of the preference that some stakeholders have towards APs as an information source, those who favor this source include labor, APs, and Board of Industrial Insurance Appeals Judges. In addition to the presumption towards the APs opinion, it is felt that APs know and consider the whole patient. This was felt to outweigh the physician's reluctance to rate his own patients and the fact that many physicians lack occupational medicine training. Employers and claims organizations see the situation as one in which many APs do not provide needed or impartial information in a timely manner. In addition, APs view the typical reimbursement as being inadequate for time spent on coordination and reports. They prefer e-mail as a means of communication, although that is typically not available at L&I.

The interviewees perceive that more use of an AP's consultants could substitute for IMEs in those situations where the AP is unfamiliar with the condition or when there is a reluctance to perform an impairment rating. In general, the view is that the current IME process through brokers is easier than this alternate approach. Several interviewees observed that an AP with a specialty in Occupational Medicine can pro-actively obtain/supply all the needed information. For this to be effective, system reforms would need to include appropriate incentives. It was noted that this approach worked very effectively in the Department's recent Managed Care pilot.

To the issue of why IMEs are performed, most felt that they are obtained to close a case (perceived as 80% of exams), including the determination of fixed and stable status, functional capacity, and impairment ratings. In addition, it was observed that IMEs are ordered to accelerate progress in a case, especially when it is not clear why the injured worker is not back at work or why continued treatment is being provided. To a lesser extent, it is perceived that IMEs are ordered to validate an AP's or worker's assertions

with respect to a variety of factors, including causality, a proposed treatment plan, or the ability to work.

The reported perceived appropriate uses of IMEs are to:

- Evaluate re-openings, closures
- Assess the appropriateness of case closure
- Evaluate additional conditions
- Suggest a course of action, although this should not be a substitute for training, knowledge, or experience of the referral source
- Support judicial proceedings, including meeting rules regarding the preponderance of evidence, although this is tempered by the AP being perceived as more credible, and the dependence on the independent examiner's skill as a witness.

Respondents felt that repeated IMEs are common. They felt that the reasons for repeat IMEs were to:

- Remedy "poor quality" exams
- Get a "preponderance of evidence", although judicial stakeholders noted that one "good" witness outweighed many weak ones
- Replace a prior exam not used before its six month expiration under current policy.

However, our review of reports did not support the belief that repeated IMEs are common.

The Structure of the IME Report

Respondents cited issues on the questions asked by claims examiners. It was observed that questions tend not to be specific enough. The questions are general. They are viewed as unfocused. Lastly, while the questions may be appropriate in isolation, they

are often used in groups, expanding the range of possible responses by the examiner, thus making the response less focused.

Examiner Qualifications

In general, respondents observed that training is not required, nor is any testing. Qualifications tend to be similar to those required for licensure. That is, there are few qualifications except state licensure, and no moral turpitude, felony convictions, or impairment in the ability to perform the examinations and write reports. Respondents felt it was easy to become an approved examiner. Perceptions included that it is a seller's market. Virtually any willing provider can be included. The general perception of the interview participants was that the qualifications are weak, since L&I requires only that providers must meet two of three requirements: board certification, a minimum of eight hours direct patient care over two years, and geographic need. Chiropractic examiner qualifications require two years as chiropractic consultant to the department.

Logistics and Coordination of Scheduling

Observations around logistics and coordination of exams included perceptions that there was a general lack of awareness of the IME by the attending physician. This had an impact on coordination of the exam with ongoing treatment plans.

In addition, claimants were often scheduled without agreement, which contributes to a relatively high no-show rate and perceived worker dissatisfaction.

The information transfer process was viewed as duplicative, disorganized, and incomplete. The information transfer via microfiche was seen as creating extra steps and cost.

Examiner Supply and Selection

Perceptions of examiner supply focused on availability, qualifications, retired examiners and a perceived supply/demand mismatch. Constraining examiner availability is the perception that IME work is not desirable to many practicing physicians. The "assembly line scheduling" increases income-efficiency but reduces physician perception of the value of the work. Compounding these views are perceptions that reimbursement is inadequate, that L&I is viewed as bureaucratic, and that the process is seen as irrational. This leads to a general reduction in satisfaction.

Most interviewees, other than physicians, mentioned the issue of retired examiners. The opinion varied by the source, with brokers feeling that examiners retired from active practice had both a better "bedside manner" and were less rushed, having more professional energy for exams. IME physicians feel that skills remain current for several years after retirement. Board of Industrial Insurance Appeals judges questioned the credibility of examiners in retired status. The supply / demand mismatch varies with geography, specialty and service required (e.g., credibility, medical accuracy, writing skills, bedside manner, rating know-how).

The use of multi-examiner exams increases the size of the examiner pool required for a given volume of injured workers. Interviewees concluded that multi-examiner exams are often unnecessary. They are not viewed as improving the credibility or quality of the IME. A large volume of these exams could exacerbate the supply constraints experienced by L&I.

To the extent physicians with a bias are included in the pool of examiners, and if there is a reluctance to use them because of this bias, then the effective supply of examiners is again reduced. While not perceived to be a significant issue by the interviewees, it is felt that those physicians with a bias are well known since patterns are observed.

Use of IME Brokers

The use of IME Brokers was an area in which virtually all interviewees had opinions. The major opinion was that they are believed to perform valuable services, including:

- Recruiting, assessing, managing, scheduling, and paying examiners
- Organizing and obtaining materials
- Orchestrating appointment logistics, accelerating the overall exam and subsequent reporting process
- Improving report quality, although this may lead to altering the content of the report

This view was not universally held. Some interviewees, including some physicians and some claims personnel, perceived IME brokers negatively. They felt they added little value.

Interviewees believed that brokers were performing functions L&I would otherwise have to perform. Brokers are reported to consume over half of the fee, which has the effect of creating a vested interest in the business for the broker, but reducing the effective compensation to the physician performing the exam.

Use of Panel Exams

The interviewees believe there is a reliance on panel exams (multiple providers), as a way to achieve preponderance of evidence, (e.g., 3-person panel vs. 1 AP) and that brokers and examiners prefer panels because they maximize revenue. The judicial interviewees indicated that this tactic generally carried little weight in their decisions. Citation of objective medical evidence and a clear, logical summary of how their conclusions were reached carried far more weight.

IME Content-related Perceptions

A subset of the broader group of stakeholders was able to respond to the issue of IME report content.

Questions Posed and Responses

Perceptions regarding the questions asked in the request letter included that the questions were often seen as irrelevant, too late in the claims process to have any substantive impact, and too vague.

The responses in the IME reports were sometimes viewed as non-responsive. There was a concern that IME physicians may provide opinions on questions that were not asked. In addition, reports were perceived as "boilerplate" by having an unvarying format, and having physical exam results that did not reflect a focus on the affected body parts or systems.

Completeness

Perceptions about completeness and thoroughness include that some answers were felt to be incomplete, time spent with the patient was often perceived as inadequate, especially by assisting examiners in panels, and the basis for an opinion was often seen as weak due to the inadequacy of record review or excessive reliance on a single item in a chart.

Logic

Perceptions about report logic include that it is sometimes questionable, although this may be attributable in part to a difference between opinion and evidence-based logic.

Other Content Perceptions

It was perceived that the language level was often stilted or too high and that a clear and succinct statement of findings was often missing from the report.

The stakeholders did not offer opinions regarding the accuracy of ratings.

Opinions of the bias inherent in IMEs included that if a patterned response for a given examiner was seen, he or she was viewed as biased. In general, organized labor's view of IMEs is that they are defense exams. Workers who have bad experiences with the system find that the IMEs are not credible.

Quality Management and Improvement

Observations about the systems of quality control and improvement are that the current systems include quality assurance at the panel level, ensuring correct grammar, spelling, and format. L&I maintains the complaint assessment process and response mechanism. Brokers conduct exit surveys, but these tend to focus on logistics. There is no mechanism for quality control nor is there a measurement system to serve as the basis for ongoing quality improvement efforts, including scorecards and feedback mechanisms.

Performance Evaluation Areas

Based on our understanding of the IME process, its perceived purpose and the shortcomings identified during the stakeholder interviews, we established 6 expectations for a "best practice" IME process. They are:

1. IMEs accurately and completely answer questions asked by the claim manager.
2. A reliable and consistent process exists for administering and obtaining high quality IMEs.
3. The injured worker is treated with dignity and respect.

4. Attending physicians find IMEs useful, accurate and credible.
5. IMEs are performed and reported in a manner consistent with L&I rules, regulations, and guidance.
6. IMEs are performed by a qualified, competent and credible pool of examiners.

These 6 expectations are listed below, each one compared with the pertinent findings about the current situation from the four steps: stakeholder interviews, the injured worker survey, the attending physician survey, and the IME report audit.

Expectation 1: IMEs accurately and completely answer questions asked by the claim manager.

Findings:

- IME request letters, as represented by the audit sample, are so standardized that they do not guide the examining physician to the key issues or concerns needing explication or resolution.
- The 80% of examinations requested in order to close a case asked for a large amount of unnecessary data. Questions about causation are generally asked long after the case has been accepted and causation is no longer at issue. Similarly, questions about the appropriateness of treatment and ability to work are asked after the fact. These issues could have been quite important at early stages of the case, but have limited value at the end.
- IME reports (as represented by the audit sample) only partially answer the questions posed by claim managers. The accuracy of responses is quite variable. Opinions are most often presented without a clear explanation or rationale for recommendations, ratings and conclusions. There are also a substantial number of errors in calculation of impairment ratings.

Expectation 2: A reliable and consistent process exists for administering and obtaining IMEs.

Findings:

- Stakeholders interviewed did not complain about, nor did we observe, unreasonable delays or inefficiencies in requesting and obtaining IMEs. However, it is a slow process and we know from other feedback the Department has received that there is stakeholder concern about the timeliness of the cumulative process. The total median turnaround time from request to delivered IME in our audited sample was 57 days.
- We did note that most IME requests specified multiple examiners who specialize in various aspects of the injured body part, most often orthopedics and neurology. This practice is unique to Washington.
- Organized document sets (claim, medical and disability summaries, chronological and categorized medical records, imaging and electrophysiological studies, etc.) do not appear to be uniformly provided for examiners. The claims summaries should provide a focus for the examination and the report. Poor document sets mean that examiners cannot demonstrate that their opinions are grounded on a solid understanding of the facts, which weakens the reports.
- IME brokers are not consistently producing reports of uniform quality, nor does the examination process appear to be consistent.
- Quality management is limited to a response to complaints from injured workers and claim managers including complaints about rating, not answering questions, and timeliness.

Expectation 3: The injured worker is treated with dignity and respect.

Findings:

- In terms of overall satisfaction with the examination, about 72% of examinees surveyed felt that they experienced at least one problem during the examination.
- L&I schedules appointments unilaterally. The claimant is simply notified in a

letter that could be construed as a "summons to appear." While about 75% of the injured workers surveyed felt that the time between scheduling the exam and the appointment date was reasonable, more than 1 out of 3 felt the examination process did not consider their needs.

- Approximately 90% of workers reported being treated well by medical office staff. About 75% felt that the IME doctor(s) treated them with dignity and respect, leaving 25% who felt they were treated poorly. Almost 80% of respondents reported that the IME doctor was professional, and more than 20% felt their doctor was unprofessional. About 66% stated that they did not experience unnecessary discomfort during the exam, while 33% stated they did experience unnecessary discomfort during the exam.
- About 70% of injured workers thought the IME doctor was informed about their problem. More than 30% of injured workers stated that the IME doctor was somewhat uninformed or not at all informed about their work-related health problem and felt that the IME doctor(s) did not spend an adequate amount of time with them.
- More than 75% of examinees surveyed stated that the office or examination room did not meet their expectations of a professional medical office.
- We noted very few evaluations in our IME file audit that appeared to be unusually frequent or requested for inappropriate reasons, especially given the long length of time that many injured workers had been under treatment or out of work.

Expectation 4: Attending physicians find IMEs useful, accurate, and credible.

Findings:

- About 25% of attending physicians surveyed said they gained some new information or perspective from the IME.
- 75% of physicians surveyed said that they received copies of the IME reports. Of those that saw the findings, 75% said they agreed with them.
- 25% of attending physicians said that IMEs disrupted the timing of treatments for their patients.

Expectation 5: Independent Medical Examinations are consistent with L&I rules, regulations, and guidance.

Findings:

- Stakeholders did not report that L&I's expectations for IMEs are unclear. L&I has updated and improved its handbooks for attending physicians, chiropractic examiners, and independent medical evaluators.
- Stakeholders did not complain that IME providers fail to comply with the regulatory structure or guidance they had been given. However, the IME exams we audited were not consistent in form or extent of detail, and generally did not conform to the template IME provided by L&I, most particularly with respect to occupational disease evaluations and impairment ratings. Nor could we find any evidence of L&I enforcing any uniform standard for report structure or content.
- A number of data elements cited as best practices in our research are not presently required by L&I handbooks. Examples include positive identification of the examinee, attestation that the examiner has informed the injured worker of the nature and output of the exam, documenting the amount of time spent reviewing records and with the examinee, offering opinions as to the consistency and credibility of the examinee, matching abilities to essential job functions, analyzing work-relatedness, and clearly explaining the logic for recommendations, ratings and conclusions.

Expectation 6: IMEs are performed by a qualified, competent and credible pool of examiners.

Findings:

- Based on the poor results of the IME audit, it is clear that being a specialist in a particular body system does not correlate with the ability to produce excellent independent medical examinations or reports.
- In the examiner approval process, L&I requires that each examiner meet two of the following three criteria: 1. Have some direct patient care (average of 8 hours or more per week in the past two years), 2. be board certified in their area of medical specialty, and/or 3. meet a geographic need, determined by the Department on a case-by-case basis. Expertise in addressing many issues (causation evaluation, treatment assessment, return to work assessment, and impairment assessment) is not required either by L&I or by the IME brokers who provide most of the IMEs in Washington, nor is expertise, or certification in occupational health issues and independent medical evaluation required.
- The supply of good examiners is clearly inadequate for the current demand under the present system. More than 70% of attending physicians surveyed do not want to do impairment ratings on their own patients. Most practicing physicians do not view IME work as desirable due to the non-healing purpose, the low perceived value of the work, and low reimbursement.
- Some stakeholders suggested that IMEs in Washington might be biased towards employers. In the injured worker survey, however, about the same numbers of respondents reported that the doctor seemed to have a bias in favor of them as reported a bias in favor of L&I. Also, we found little or no evidence of overt bias in the IME reports we audited.

Summary Findings of Performance Evaluation Areas

There are numerous opportunities for improving the IME process in Washington. There are specific problems occurring at each step in the process so that it:

- creates at least one problem for the majority of injured workers,
- fails to consistently deliver appropriate materials to the examining doctor, and
- fails to consistently deliver high quality IME reports back to the claim manager.

Many of the specific issues raised are shared to varying degrees by many other jurisdictions and claims payers. Many potential improvements appear likely to cost reasonable amounts of money, time, and effort. They have significant benefit, and are, therefore, worthy of consideration.

Summary Findings of the IME Report Audit

Independent Medical Examinations paid for in calendar year 2000 for the Washington State Department of Labor and Industries were variable in form, content, and level of detail. Form varied among IME brokers and to a lesser degree within each broker company. The level of detail presented was quite variable, ranging from complete and clear to fragmented and summary. The level of analysis presented ranged from non-existent to excellent, with the majority of analyses being cursory. In a substantial number of cases, the opinions in the IME reports examined in the audit were not supported by the evidence base and guidelines available.

The format and areas covered in the IME reports audited appear to be uniform within each IME broker. To a substantial degree, this appears to be the result of the repetitive use of a set of broad, standard questions for IMEs requested for any issue. When the same broad questions are asked, the reports tend to look similar.

IMEs obtained in Washington can be improved by presenting a *well-reasoned* opinion based on a demonstrated understanding of the key facts and evidence in a case. Scientific evidence and guidelines were in fact rarely cited, and analysis and decision logic were lacking or incomplete. In many cases, it appears that the examiners simply accepted prior opinions. This lack of reference to facts and analysis renders the reports less than optimally useful in legal dispute resolution, and in furthering the understanding of the case for care and disability management.

The weakest areas of the reports, as a group, were the history of the case, and analyses, particularly analyses of causation, previous care and disability management, and the overall course of the case. Explanations of the logic for recommendations, ratings and conclusions were also weak or missing. Explanation of ratings was quite variable, typically not referencing specific criteria. Shoulder ratings were generally explained, however several of these ratings were erroneous. Low back soft tissue complaints and hand and wrist nerve compression were more often than not hard to understand and questionable. What was lacking, then, was an organized, systematic summary of the case history from prior records, an independent causation assessment, a critical assessment of the adequacy of previous care, and, for any required topic, an explicit analysis based on cited facts.

In comparing the reports as a group to customer (typically claim manager) expectations (previously outlined on page 14) we noted the following:

- *The IME accurately and completely answers the questions asked* (Expectation #1, p.22)

  There seemed to be less than full satisfaction of the informational needs of the claim manager in many of the IME reports reviewed. There were very few clear explanations of the logic used to arrive at causation, diagnoses, appropriate treatment plans, and maximal medical improvement.

In at least three important areas, the sample of IME reports reviewed was inconsistent with criteria for excellent IMEs. The first area was causality logic. Causation is an issue for any new claim, for newly contended conditions, in assessing medical indications for re-opening claims, and for identifying the relatedness of complications. **Correct attribution of causation** is important both for work relatedness and for apportionment. As outlined in the next section, reports did not typically meet criteria.

Secondly, past and recommended treatment plans should be consistent with evidence for appropriateness and effectiveness, usually found in clinical practice guidelines or meta-analyses. Retrospectively, the examiner is expected to review previous treatment plans. Prospectively, the examiner may be asked to review recommendations for further treatment, or to make such recommendations. Again, there was **rarely a critical analysis evident**.

Thirdly, in order to assess whether the claimant has achieved maximal medical improvement and is fixed and stable, the examiner would be expected to assess functional abilities. Areas of function include general abilities and function, activities of daily living, and work abilities compared to job requirements. The reports **did not adequately define functional abilities**.

- *A streamlined, reliable and consistent process exists for administering and obtaining high quality IMEs* (Expectation #2, p. 23)

The process of requesting an IME from schedulers, and of notifying the examinee appeared consistent from the documentation presented. The request letters demonstrated consistency in using the same group of standard questions. However, the questions were not focused on specific case issues for the most part. Time intervals appeared to be reasonable and consistent, with some exceptions. Schedulers consistently used IME broker companies. The process for selecting the IME broker companies was not clear from this audit, however. **There did not**

appear to be a systematic quality management process in place at the IME broker companies.

- *IMEs are consistent with L&I rules, guidance and regulations* (Expectation #5, p.25)

  We observed that the reports generally followed L&I guidance in the *Medical Examiners' Handbook* and the relevant WACs. However, L&I guidance about format, required data elements, and logic and analysis could be more explicit and detailed.

  In order to be credible, and therefore useful, in the legal process, an IME report must present clear statements of facts, comparative evidence, and logic. As discussed in the Detailed Audit Results beginning on page 84 of Volume 1, Chapter 2, (Deliverable 6), several of the **greatest deficiencies** in the IME reports reviewed were **the dearth of reference to scientific evidence or guidelines, and clear explications of logic for a variety of conclusions.**

- *A qualified, competent and credible pool of examiners performs IMEs* (Expectation #6, p.26)

Our inference from this IME report audit is that while examiners appear to be competent physical examiners in general, and appear impartial, **they have not acquired the specialized skills needed to prepare an excellent IME report**. Further, at least one auditor felt that they took the path of least resistance by simply accepting prior diagnoses and conclusions. One physician-reviewer observed, "Physicians who stated they were credentialed in the performance of these evaluations, either as a Certified Independent Medical Examiner (American Board of Independent Medical Examiners) or a Fellow of the American Academy of Disability Evaluating Physicians performed only a few of the evaluations." **The number so**

certified was not sufficient to demonstrate whether quality was significantly different between those certified and those not certified.

Reviewers consistently noted that the **explanation of the logic and basis for opinions rendered in the reports were rarely present**. This has a significant impact on the usability of the IME report to the claim manager and personnel without medical training. This also **may affect an examiner's credibility** if he or she is later called to testify in legal proceedings.

Analysis of Best Practices Compared to Current L&I Practices

The literature review and industry leader interviews revealed little structured analysis of best practices in the IME area. The following table lists specific areas and topics identified in the best practices research, and compares those practices to current L&I practices.

Area	Topic	Best Practice	Current L&I Practice
Rates of IME use	Comparative rates	Low usage, information is gathered in other ways	One of the highest rates in U.S.
	Limits	Avoid multiple IMEs in short time frame (6 months); must use information promptly	Not studied
	Alternative dispute resolution	Use Managed Care Organization -like mechanism as much as possible	Not in effect
Requirements	Legal, regulatory	Specify appropriate content by informational need, e.g. causality, treatment, impairment, and specify completely in regulation	Current WAC specifies an incomplete list; Handbook/IME template quite good; may require revision, however, and requirements/incentives for their use may be appropriate
Reasons for Requesting IMEs	Diagnosis	Obtain IME if medical consultant cannot negotiate correct diagnosis with AP; diagnosis esoteric	Asked in almost every IME reviewed for this study
	Causation	Obtain IME if medical consultant cannot negotiate logical causation with AP; or if imputed cause is esoteric or unclear	Asked in almost every IME reviewed for this study
	Delayed functional recovery	Obtain IME if medical consultant cannot determine issues and develop plan with AP and case manager	Rarely asked
	Prolonged treatment	Seek opinion of appropriateness early in treatment period if medical consultant cannot negotiate with AP	Asked occasionally after very prolonged treatment, usually as part of MMI/rating question
	MMI	Seek opinion at early time point if medical consultant cannot reach agreement with AP	Ask at end of case with rating
	Impairment assessment	Obtain assessment from AP when possible; have insurer calculate / assign rating	Obtain complete IME in most cases, rather than impairment assessment only. Examiner assigns rating.

Area	Topic	Best Practice	Current L&I Practice
	Alternative sources of information	Review records; ask attending physician, informal or formal in-house consultation, or file review	Usually obtain IME after requesting information from the AP and the information request is ignored
	Admissibility	Agreement to admit records	Act as if IME were admissible
Examiner qualifications	General	Knowledgeable and current about body area and issue at hand	Done by specialty, without reference to training in causal analysis, use of guidelines, or the IME process and reporting
	Credentialing	Include structured review of work product as a demonstration of competency, skills, and actual performance.	L&I requires each examiner to have some direct patient care and board certification in their area of medical specialty
	Certification	Require certification	Limited, per credentialing practice
	Training	Require training, cover all areas	Only required for chiropractors
	Use of APs	Use AP information as much as possible if clear, high quality and prompt	Only received in minority of cases due to AP resistance
Sources of IME examiners	Recruitment	Ask for application or professional society nomination; use University units	L&I relies on panel companies to recruit examiners
	Networks	Use small, trained, quality managed network	Not done
	Brokers	Require structured quality management	Requirements are minimal
IME Requests	Who orders	Adjuster and medical professional	Adjuster only
	Choice of examiners	Match skill set to issue	L&I requests specialty, but not the specific examiner or skill set, choice left up to panel companies
	Specialty	Expertise in issue, body area	Request by ABMS specialty to panel companies
	Number of examiners	One unless issues are multi-system	Multiple examiner IMEs are common
	Questions	Specific to issues and facts in the case at the point in time; include clear medical summary	Generic and general questions asked; summaries absent or claim-related rather than medical
	Frequency of issues	Delayed recovery, causation, diagnosis, treatment are most common issues	Impairment with causation, diagnosis, MMI, future medical are most common issues

Area	Topic	Best Practice	Current L&I Practice
	Provision of records	Relevant, in chronological and category order, no duplicates; in advance; electronic, if available; accompanied by inventory list	Quality of microfiche record is variable, may be incomplete or may be late, inventory list seldom provided, job information usually missing. Corrections to the records are not getting back into files.
	Fees	Fair fee to examiner for time spent	Fee schedule to panel company
Evaluation process	Scheduling	Examiner's office arranges with examinee	"Summons to appear" from L&I
	Travel distance	Convenient to claimant and condition	Not specified; attempt to schedule in closest locale but results range from local to cross-state
	Examinee identification	Positive identification; record process used and ID	Not recorded
	Declarations	State and record independence, neutrality, non-treater	Not recorded or partial boilerplate
Evaluation Content	Record review	List in order by category; summarize but include primary data	Combined with patient history at times; usually incomplete; no lists noted
	History	Include appropriate, detailed history: past medical, social, employment, job/work/ occupational, present health problem with mechanism, prior symptoms, signs, treatment	WAC specifying report content is incomplete; result is that reports typically lack employment and occupational histories, work situation; history of current problem sketchy
	Inventories	Use and discuss questionnaire, pain inventories, symptom inventories as appropriate	Not recorded or found only in minority of files reviewed
	Claimant reliability	Include opinion of reliability, consistency with examples	Not recorded
Analysis	Diagnosis	Match guidelines carefully	Usually accept prior diagnoses without analysis, rarely explain logic/rationale
	Causation	Use careful logic compared to evidence and exposures	Usually accept prior causation analysis without critique, rarely use evidence or explain logic/rationale
	Prior testing	Review primary materials, interpret, comment on timing and prior interpretations	Usually quote prior interpretations briefly, accept as appropriate

Area	Topic	Best Practice	Current L&I Practice
	Treatment appropriateness	Compare to guidelines, comment on appropriateness with logic shown	Rarely comment on this; typically accept as reasonable, especially surgery
	Delayed functional recovery	Seek risks and reasons, list with remedial suggestions	Not seen in any exams reviewed
	MMI	Compare treatment to guidelines; delayed recovery risks	Usually appear accurate, but logic not given
	Impairment assessment	Follow a formal system, listing detailed methods and rating	Highly variable accuracy and explanations
	Future medical treatment	Forecast needed treatment quantitatively	Typically no or vague statements
	Recommenda-tions	Evidence-based in response to specific questions or needs	Rare; not usually explained even when present
Quality Management	Quality assurance	Delegate by contract to brokers if used; respond to substantive complaints with analysis and evidence	Complaints routed to examiner for response
	Quality control	Delegate by contract to brokers if used; routine medical content, logic audits and feedback	Not done
	Quality improvement	As above with statistical feedback and means for systemic improvement	Not done
Satisfaction	Claimant	Third party, rolling, stratified surveys; statistical feedback to examiners	Delegated to IME brokers; not tabulated or used; very broad questions
	Attending physician	Third party, rolling, stratified surveys; statistical feedback to examiners	Not done
	Claims staff	Periodic stratified surveys; statistical feedback to examiners	Not done
	Legal staff, judges	Periodic surveys; statistical feedback to examiners	Not done
	Employers	Periodic surveys; statistical feedback to L&I, Claim Managers and examiners	Not done
	IME Examiners	Periodic surveys; statistical feedback to L&I and Claim Managers	Not done

Area	Topic	Best Practice	Current L&I Practice
Outcomes	Effective use of information in claims, care quality improvement	Tabulation of audit results tracking use of information; feedback, systemic improvement	Not done
	Effective use in dispute resolution	Tabulation of audit results tracking use of information; feedback, systemic improvement	Not done